Strategy Research Project

DOD-VA HEALTH CARE: A CASE STUDY IN INTERAGENCY REFORM

BY

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USAWC CLASS OF 2008

U.S. Army War College, Carlisle Barracks, PA 17013-5050

Report Documentation Page

Form Approved
OMB No. 0704-0188

1. REPORT DATE	2. REPORT TYPE	3. DATES COVERED
15 MAR 2008	**Strategy Research Project**	**00-00-2007 to 00-00-2008**

4. TITLE AND SUBTITLE	5a. CONTRACT NUMBER
DoD-VA Health Care: A Case Study in Interagency Reform	5b. GRANT NUMBER
	5c. PROGRAM ELEMENT NUMBER
6. AUTHOR(S)	5d. PROJECT NUMBER
John Cho	5e. TASK NUMBER
	5f. WORK UNIT NUMBER
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)	8. PERFORMING ORGANIZATION REPORT NUMBER
U.S. Army War College ,122 Forbes Ave.,Carlisle,PA,17013-5220	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)	10. SPONSOR/MONITOR'S ACRONYM(S)
	11. SPONSOR/MONITOR'S REPORT NUMBER(S)

12. DISTRIBUTION/AVAILABILITY STATEMENT
Approved for public release; distribution unlimited

13. SUPPLEMENTARY NOTES

14. ABSTRACT
See attached

15. SUBJECT TERMS

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			
unclassified	**unclassified**	**unclassified**	**Same as Report (SAR)**	**34**	

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USAWC STRATEGY RESEARCH PROJECT

DOD-VA HEALTH CARE: A CASE STUDY IN INTERAGENCY REFORM

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This SRP is submitted in partial fulfillment of the requirements of the Master of Strategic Studies Degree. The U.S. Army War College is accredited by the Commission on Higher Education of the Middle States Association of Colleges and Schools, 3624 Market Street, Philadelphia, PA 19104, (215) 662-5606. The Commission on Higher Education is an institutional accrediting agency recognized by the U.S. Secretary of Education and the Council for Higher Education Accreditation.

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ABSTRACT

AUTHOR: Colonel John M. Cho

TITLE: DoD-VA Health Care: A Case Study in Interagency Reform

FORMAT: Strategy Research Project

DATE: 10 March 2008 WORD COUNT: 5,922 PAGES: 34

KEY TERMS: Universal, Crisis, Catastrophe, Transformation

CLASSIFICATION: Unclassified

Recent national catastrophes demonstrate that the United States interagency must expand its capacity to expeditiously respond to issues of national importance. Some experts are calling for sweeping interagency reform (IAR) - as reform is often successful when Congress supports and directs legislation born out of calamity. Clearly, there needs to be a better way to improve interagency collaboration than this “reform after disaster” paradigm. Ideally, interagency coordination absent the need for major IAR legislation is preferable. Examination of the DoD-VA health care partnership in the aftermath of Walter Reed provides new insight into the timing, proportion, and necessity of IAR legislation for improving interagency collaboration. The legacy of this partnership will ultimately depend on its ability to successfully transform ahead of the impending U.S. health care catastrophe. Recommendations are provided to strengthen DoD-VA coordination and build further capacity. The ability of this partnership to mitigate the effects of this imminent national health care crisis will arguably provide the first template for major interagency “transformation before catastrophe.” Embracing these recommendations also will secure the DoD-VA partnership’s position as a model for universal access to health care for all Americans.

DOD-VA HEALTH CARE: A CASE STUDY IN INTERAGENCY REFORM

The events of September 11, 2001, Operation Iraqi Freedom, and Hurricane Katrina demonstrated that the United States interagency must expand its capacity to quickly and effectively respond to issues of national importance.[1] In response to subsequent post-event Congressional inquiry, "Blue-Ribbon" Panel, and Ad-hoc Commission member testimony, experts and critics are now calling for legislation- much like the military transforming Goldwater-Nichols Department of Defense (DoD) Reorganization Act of 1986 (Goldwater-Nichols Act, G-NA) - that would fix coordination deficits through wide-sweeping interagency reform (IAR).[2] The timing for such legislation is critical as the Beyond Goldwater-Nichols (BG-N) Phase II Report aptly highlights that the implementation of reform is often successful when Congress supports and directs legislation born out of catastrophe.[3] New legislation would most likely focus on national security IAR. Epiphenomena of this law would include enhanced and timely coordination among all Departments within the United States (U.S.) government.

Unfortunately, just as it took four years and 241 days to enact the G-NA, radical and expansive national security IAR will not be codified into law anytime soon.[4] For the near-future, incremental initiatives will continue to be the primary method of IAR legislation. These initiatives have merit as they often have as good if not a better record of success than major proposals.[5] Inherent in this assertion is the fact that incremental IAR legislation is most effective during periods of relative calm and stability. This point is best exemplified by the myriad of successful, albeit somewhat slow and measured, DoD and Veterans' Administration (VA) health care and health care delivery collaborative improvements made from 1982-2006.

In February 2007, a period of relative calm was replaced by a catastrophe when problems at Walter Reed (WR) were revealed.[6] What ensued were multiple Congressional oversight hearings and Executive Branch commissioned independent reviews.

While a lack of timely outpatient care and suitable facilities for wounded Soldiers were the initial focus of attention, these issues were merely a reflection of larger systemic problems.[7] A number of these problems were not specific to WR but rather were the result of outdated institutional policies and procedures. Issues requiring better interagency coordination between to the DoD and VA were also noted. The end result was the passage of the Wounded Warrior Act (WWA) as part of Public Law 110-181, the National Defense Authorization Act for Fiscal Year (FY) 2008.[8] In addition to addressing issues identified at WR, the WWA mandated a "seamless transition" for Soldiers moving from the DoD to VA health care system. Given that the DoD and VA partnership- as it existed immediately after the events of WR- had "unity of purpose" but not "unity of command," a temporary executive level agency, the Senior Oversight Committee (SOC), was established to ensure that both Departments remained committed to implementing WWA legislation.[9]

Examination of the post-WR DoD-VA health care partnership is in essence then a case study on the timing, proportion, and to some extent necessity of IAR for improving interagency cooperation. Ideally, successful interagency coordination without the need for major IAR legislation is preferable. Does the current DoD-VA partnership fit this paradigm? In particular, could the DoD and VA successfully implement future Congressional legislation absent the SOC? More importantly, as the U.S. is arguably on

the verge of a health care crisis, does the DoD-VA partnership have adequate capacity to deliver quality, effective, and timely care to beneficiaries in this uncertain and complex 21st Century health care environment? This last question is especially apropos as neither health care system would be exempt from the effects of a national health care catastrophe.

What follows is an examination of multiple different but related factors present or just on the horizon that contribute to this impending health care crisis and necessitate accelerating the pace of health care centric interagency collaboration. A good starting point will be an analysis of the impact of IAR legislation in transforming the DoD-VA partnership to its present form. The research will demonstrate that the DoD-VA health care partnership has improved dramatically over time and is actually now well suited- even before the establishment of the SOC - to successfully implement the WWA as well as any future legislation. In fact, an argument will be made not to codify the SOC into law. However, enhancements to the current DoD-VA partnership will be necessary to minimize the impact of the coming health care crisis. Recommendations to strengthen the DoD-VA partnership by building additional capacity are provided. Finally, this paper will identify which level or proportion of IAR legislation- incremental, moderate, or major- is feasible, acceptable, and suitable (FAS) to avert a federal health care disaster in the event that the DoD-VA partnership cannot or will not implement these recommendations.

The DoD-VA Health Care Partnership

The transformation of the DoD-VA health care partnership to its current form is a result of progressive improvements in collaboration brought about by a repeating cycle

of accountability and reform. The main components of this cycle include: Congressional inquiry as part of oversight responsibility, generation of a GAO[10] report in response to a Congressional request, GAO IAR recommendations enacted into law, improvement in DoD-VA interagency collaboration, and the eventual return to Congressional inquiry as new issues arise. The focus of DoD-VA IAR for each cycle correlates with the predominant U.S. health care model in effect during three distinct but consecutive periods: excess capacity (1978- 1993), managed-care (1994- 2000), and consumer directed health care (2001- 2008). Examination of these periods provides the insight necessary to fully appreciate the dramatic improvement in DoD-VA collaboration over time.

Coordination between the DoD and VA did not come about spontaneously. The impetus for improving DoD and VA interagency collaboration was the Congressionally requested 1978 GAO/HRD Report-78-54.[11] This report led to the passage of Public Law 97-182, the VA and DoD Health Resources Sharing and Emergency Operations Act of 1982 (Sharing Act). The Sharing Act encouraged the DoD and VA, collectively known as the federal health care system, to seek efficiencies by finding "common ground" between these initially disparate organizations.[12] Finding common ground however usually meant moving forward only in areas that met the needs of both health care systems- otherwise known as embracing the lowest common denominator.[13] This arrangement was conducive to a cordial relationship but often shunned meaningful improvements to beneficiary care- from the federal government's perspective- in the presence of interagency disagreement by either the DoD or VA.[14] In spite of parochial interests, by 1986 there were 240 resource sharing agreements between the DoD and

VA.[15] Problems remained however, and in one case, the Chairman of the House Committee on Veterans Affairs had to personally intervene to get DoD and VA officials to sign a sharing agreement allowing CHAMPUS[16]-eligible beneficiaries to receive care at a VA hospital.[17] In 1994, CHAMPUS was replaced by TRICARE- a single managed-care program for the Armed Services.[18] The inception of TRICARE soon added a new set of challenges to DoD-VA collaboration.

Although managed-care was present in the United States in the 1980's, the DOD and VA did not support this concept until the mid-1990s. The premise of managed-care was to support quality while seeking efficiencies, cost savings, and right-sizing initiatives by appropriately managing- and in some cases limiting- access to health care.[19] In 1995, the DoD and VA fully embraced the tenets of managed-care.[20] This shift made it more difficult for the DoD and VA to share resources. Excess capacity within each health care system was eliminated in the name of efficiency and cost containment. By 2000, the DoD had closed one-third of its Military Treatment Facilities (MTF) - hospitals and clinics- and the VA had eliminated over 20,000 inpatient beds.[21] Additionally, TRICARE managed-care contractors often directed care to private-sector organizations over the VA. In some cases, the local TRICARE contract made it illegal to refer a beneficiary to the VA unless the respective VA Medical Center (VAMC) was part of the network.[22] Even when a VAMC was a TRICARE network partner, issues of billing and reimbursement made resource sharing cumbersome and cost-prohibitive.[23] Recognizing this friction, the GAO in 2000 was quick to recommend that the DoD and VA make an earnest attempt to resolve these unintended consequences of embracing managed-

care. The GAO however also suggested that Congress should step in to provide the DoD and VA direction and guidance if inertia set in.[24]

As it turned out, the premise upon which the concept of managed-care was built proved fallacious. The failure to restrain health care costs ultimately led to its undoing.[25] As early as the late-1990s, managed-care plans began to shift health care decision making and costs- in the form of higher premiums, deductibles, and co-payments- to patients.[26] The decline of managed-care in the United States led to a similar movement away from aggressive health care management approaches within the DoD and VA. This tacit approval of a more patient-centric approach to health care summoned the arrival of consumer directed health care to the federal health care system.

The rise of consumer directed health care in the United States led indirectly to an improvement in collaboration between the DoD and VA. Congress now had a new and vocal partner, the beneficiary- also known as the consumer- to advocate for quality, effective, and timely patient-centric health care services. The number of GAO reports specifically addressing DoD and VA health care collaboration increased from two, to eight, to fifteen as the federal health care system transitioned from the period of excess capacity, to managed-care, to consumer directed health care. The rapidity of each new cycle- of Congressional inquiry, GAO reporting, IAR legislation, and DoD-VA collaboration- during the most recent period appears to correlate with Congressional interest in accelerating the pace of DoD-VA IAR. Consumer calls to deliver on the promise of a truly seamless transition from the DoD to the VA emboldened Congress to demand expeditious results on behalf of these federal health care beneficiaries. The fact that thirteen of the last fifteen Congressional GAO requests were generated after

2001 and before WR suggests Congress' growing impatience with the tempo of DoD-VA interagency progress in dealing with the secondary and tertiary effects of OEF and OIF. As the research that follows demonstrates, this impatience was in spite of tremendous progress made in DoD-VA coordination and collaboration.

By late-2001, the DoD and VA leadership clearly understood that a shift in health care was underway. These federal agencies went from being the proverbial driver as proponents of managed-care to taking a backseat in the new consumer led and directed health care environment. In February 2002, the VA-DoD Joint Executive Council (JEC) and Health Executive Council (HEC) were established. The JEC was formed to provide senior leader oversight for coordination and resource sharing. Later, the JEC added strategic planning, performance monitoring, and Congressional reporting to its charter. The HEC, a subordinate agency of the JEC, was specifically developed to enhance DoD-VA collaboration, coordination, resource sharing, and most importantly to resolve interagency differences.[27] In a 2006 report to Congress, the GAO noted the exceptional progress made since the establishment of the JEC and HEC.[28] Even the opportunities for improvement identified in that GAO Report - namely the development of strategic performance measures and a standardized evaluation plan to assess Joint Incentive Fund projects- were quickly and successfully addressed by the JEC by year's end.[29] In fact, the VA-DoD JEC highlighted the significant progress that was made when presenting the FY 2006 Annual report to Congress in February 2007.[30] However, national outrage over Walter Reed that same month provided Congress the opportunity to expand the inquiry beyond the initial concerns at WR and include issues related to DoD-VA collaboration.

The recommendations from the Presidential directed Dole-Shalala Commission, the West-March Independent Review Group, Congressional hearings, and two post-WR GAO Reports formed the basis of the Wounded Warrior Act. While there is near-unanimous agreement that the WWA is a landmark piece of legislation that will significantly impact the delivery of care to our wounded, ill and injured service members, the question over whether this legislation constitutes major IAR remains.[31] As a precise definition of major IAR is unknown, a return to the Goldwater-Nichols Act – arguably the best example of successful and consequential "intra-agency" reform – is a good starting point.[32] The legacy of the G-NA is a result of a confluence of key elements essential to sustaining lasting reform. These elements include: Legislative and Executive Branch support in the face of catastrophe- the Iranian Hostage Crisis and Desert One;[33] public awareness, concern, and anger over the crisis; adequate resources made available to include Congressional funding to support the reform; and support from key individuals- to include the President, members of Congress, and IAR experts.[34] Of note, the events surrounding WR and the subsequent passage of the WWA demonstrate the presence of essentially the same elements that led to the GN-A. However, there are two significant differences between the G-NA and the WWA. One, sustaining long-term IAR vis-à-vis DoD- specific intra-agency reform may be difficult absent a permanent interagency oversight organization to mediate differences between the agencies. Second, although the tenets of the G-NA have not been completely implemented, the efficacy of this legislation in transforming the military over a sustained period of time is irrefutable.[35] It remains to be seen if the DoD-VA partnership, strengthened by the WWA, will stand the test of time and garner similar results.

Clearly, there must be a better way to ensure and improve interagency collaboration than to await a calamity. Some have suggested the creation of an overarching organization- the Office of the Director of Interagency Coordination (DIC) - that would mediate disputes and facilitate oversight, tracking, and reporting of implementation results.[36] The DIC could help to resolve differences and improve coordination, especially among Departments with disparate instruments of national power.

Although its name suggests a DIC-type construct, the Senior Oversight Committee exists only as an additional layer of bureaucracy to ensure that the JEC and HEC expeditiously implement the provisions of the WWA. As the SOC is composed of senior DoD and VA leaders, many of whom are also members of the JEC, there appears to be no benefit to codifying the SOC into law as a permanent organization. A number of SOC members agree with this position.[37] In addition, there is ample evidence- even pre-dating the events at WR- that demonstrates DoD and VA commitment to improving interagency collaboration.[38] This tremendous improvement is a result of the annual VA-DoD JEC Strategic Plan which is now in its fifth iteration (FY 2008-2010). This plan provides strategic guidance and serves as the primary instrument to measure progress, gauge success, and identify opportunities for improvement. The recent addition of performance measures, to include expected dates for implementing each provision of the WWA, provides transparency and a common interagency goal.

Although painful, the events at Walter Reed served as the “tipping point” for improving DoD-VA collaboration.[39] Prior to WR, the five year project to merge the DoD and VA electronic medical records (EMR) was on year nine and counting.[40] After WR,

the JEC appears to have miraculously overcome this problem as the two EMR systems will be operational as one by the end of 2008.[41] Thus, the DoD-VA partnership- with or without the SOC- is well-suited to implement the WWA. More importantly, this partnership provides a proven and less painful option to improve interagency collaboration outside of the current "catastrophe then reform" model. The legacy of this relationship then will ultimately depend on its ability to "transform to avoid catastrophe." The impending U.S. health care crisis will clearly test the limits of the current DoD-VA partnership.

The Perfect Storm

The emergence of new, bold, and diverse proposals to fix health care in the U.S. effectively answers the question over whether such a problem even exists.[42] Certainly the DoD and VA, two of this nation's largest health care systems, will not be exempt from the effects of a health care catastrophe. The presence of multiple but related factors both inside and outside the federal health care system provides DoD and VA leaders an excellent chance to shape the future of U.S. health care. These factors encompass both challenges and opportunities for the DoD-VA health care partnership. The challenges are not unique to the DoD and VA and are part of the national debate. They include: escalating health care costs; the rise of patient self-advocacy through consumer directed health care; public interest in universal health care coverage for all Americans- especially the uninsured; and the growing shortage of health care professionals such as physicians and nurses. The opportunities on the other hand are internal to the federal health care system and a function of recent events. Opportunities include: VA leaders who understand the DoD Military Health System (MHS); the

establishment of a Joint Task Force (JTF) which may transition to the first tri-service unified military medical command; and a greater expectation for DoD and VA professionals to deliver results in the post-WR environment. The simultaneous presence of these challenges and opportunities creates a unique milieu to accelerate the pace of DoD-VA collaboration and can best be described as a “Perfect Storm.”

U.S. health care costs continue to rise at a rate that is two times the Gross Domestic Product (GDP) per capita. This translates to $7,498 in health care expenditures per capita totaling $2.3 trillion or 16% of the nation’s GDP in 2007.[43] By 2035, Congressional Budget Office models predict that the total national health care expenditure will double to 31 percent of the GDP.[44] In other words, in the not too distant future, nearly one in three dollars earned will be spent on health care. The primary drivers for this explosion in health care costs include: a growing and aging population, the increase in health insurance coverage, medical inflation- currently 7% per annum which is 2-3 times the rate of U.S. inflation, and greater utilization of services.[45] This last factor is due in part to patient demands or self-advocacy for access to the latest technology- even when there are less expensive methods to treat a medical condition.

This rise in patient self-advocacy is in the broadest sense the basic premise for the entire consumer directed health care model. Opponents of consumer driven plans argue that these plans shift health care costs from employers to employees.[46]

As there are more “out of pocket” expenses however, these employees or consumers of heath care are demanding greater accountability and a larger voice in determining what constitutes quality. Pharmaceutical and medical technology companies recognized this paradigm shift in the late 1990s and developed commercials

suggesting that patients should "ask" or "tell" their physician to "prescribe any number of medications or tests."[47]

DoD and VA beneficiaries are similarly demanding "the latest and greatest" in medication and technology despite non-existent or nominal co-pays. Although all Veterans and their Families deserve the best health care available, the 238% rise in DoD pharmacy spending from FY 2000 to FY 2006 is quite substantial. The VA health care system is in a similar predicament as expenditures have grown 133% over 14 years to $26.8 billion as of FY 2004.[48] With each passing year, health care expenditures will require a greater proportion of the DoD and VA budget. For the DoD, health care costs will rise from the current 8% to 12% and 19% of the total DoD discretionary budget by 2015 and 2020 respectively.[49] Unless, the DoD can find a way to reduce costs, it might soon be known as a health care organization that happens to provide for national defense- as a secondary vocation.[50] Maintaining the status quo is definitely not a viable option especially as the 21st Century health care environment becomes more complex and unpredictable.[51]

Although the United States is known as the only industrialized country without universal access to health care, a movement is afoot through public and political discourse to rid us of this dubious distinction.[52] The last major attempt to garner public support for universal health care failed miserably in 1993. However, there is now a general consensus that the issues confronting U.S. health care deserve more attention.[53] No longer is it a question of whether there should be health care coverage for all Americans, but who should cover it. At the center of the discussion are 43 million uninsured Americans.[54] Clearly, the passage of any form of universal health care

legislation would have a dramatic affect on the DoD and VA health care systems-separately and in partnership. What is uncertain is whether the overall impact will be positive or negative. Regardless of the outcome, “war gaming” ahead of a national universal health policy is prudent. In the end however, the rate limiting step to universal access to health care may be not be policy implementation but rather a shortage of health care professionals.

The Department of Health and Human Services and Congressional Budget Office experts predict that there will be a U.S. shortfall of 55,000 physicians[55] and 340,000 nurses by 2020.[56] Although the reasons for this are multi-factorial, the primary issue is one of limited supply and increased demand.[57] The American Hospital Association recently identified 116,000 registered nurse vacancies in the nation’s hospitals.[58] This nursing shortage extends to the DoD and VA health care systems and is further exacerbated by competition between these Departments for the same pool of nurses. In addition, the DoD has acknowledged difficulty in convincing medical school students to accept Health Professions Scholarship Program (HPSP) scholarships. Traditionally, HPSP scholarships account for 70% of physicians accessions into the DoD.[59] In 2005, HPSP shortfalls for the Army and Navy were 44% and 23% respectively. These percentages reflect the challenge of recruiting when the nation is at War. Failure to reverse this trend will have dire consequences on the ability to support future expeditionary operations with adequate medical professionals. In response to this concern, the DoD-VA JEC FY 2008-2010 Strategic Plan includes a performance measure that calls for a 50% increase in the number of military residents in VA Graduate Medical Education (GME) Programs.[60] Clearly, more needs to be done.

Although the necessity of military GME as a core competency was recently questioned in a high-level report, the importance of maintaining quality of care and physician competency after the completion of GME training were clearly emphasized. [61] In response to consumer driven calls for greater transparency and accountability and to an initiative by the American Board of Medical Specialties, the American Board of Thoracic Surgery voluntarily mandated Maintenance of Certification (MOC) for U.S. Cardiothoracic Surgeons in January 2008.[62] The requirements of MOC include: documentation to support professionalism, life-long learning, cognitive experience, and practice performance. Demonstration of practice performance requires that a minimum of 100 cases be performed per calendar year and that the results of these operations be included in a national clinical outcome database. To meet this requirement, a number of Army Cardiothoracic Surgeons are maintaining surgical expertise by performing operations at some of the nation's premier VAMCs. Similar MOC requirements are coming on-line for other surgical specialties. Thus, the changing dynamic of U.S. medicine is providing an additional incentive for the DoD and VA to collaborate.

The BG-N Phase II Report acknowledges the importance of critical individuals in the reform process.[63] Fortunately, the recently confirmed Secretary of the VA is a former Army Surgeon General (TSG). He and other retired Flag and General Officers comprise the senior leadership of the VA; these officers clearly understand, know, and support servicemembers, the DoD-VA partnership, and the DoD MHS. As an example, the Secretary of the VA, when TSG, authorized the pilot project transferring Army Cardiothoracic Surgeons to the VA- well before interagency collaboration was in vogue.

It will be a “missed opportunity” not to accelerate collaboration while this “honest broker” is at the helm of the VA.

In October 2007, the DoD established the first Army, Navy, and Air Force medical command, Joint Task Force National Capital Region Medical (JTF CAPMED), as a prelude to a unified medical command.[64] JTF CAPMED signals a willingness to place the care of servicemembers above traditional inter-service parochial interests. The success of this organization may lead to similar organizational structures throughout the United States.[65] Eventual integration of the MHS into one inter-operable system will make it intuitively easier for the VA to collaborate with the DoD. For the time being, there remains optimism and anticipation as the North Chicago VAMC and the Naval Hospital Great Lakes merge in 2010 to become the first Federal Health Care Center (FHCC).[66] This VA- Navy Bureau of Medicine and Surgery (BUMED) led effort will have an entirely unique governance structure, an interagency Executive Committee, and will serve as a template for future DoD-VA FHCC initiatives.

Recent DoD-VA collaborative efforts to treat military personnel with Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD) in VAMCs demonstrate the common purpose and synergistic capability of these two health care systems. Clearly each health care system brings a different set of core competencies to the partnership. Arguably, some of these competencies should remain in only one Department. Others competencies however should span the spectrum of both organizations to provide the seamless transition of care which our injured servicemembers deserve. The WWA mandates an improvement in multiple “lines of operation” (LOO) to facilitate this transition. Key LOO include establishing a Center of

Excellence for Psychological Health and TBI, overhauling the Disability Evaluation System, and establishing a Federal Recovery Coordination Program to enhance case management expertise.[67] As these LOO require close coordination, monitoring progress is paramount. There is also a greater expectation now for DoD and VA professionals to deliver results especially in the aftermath of WR. It is in this high stakes environment where DoD-VA synergy is most relevant and necessary.

The scope and complexity of the impending U.S. health care crisis requires the DoD and VA to continue strengthening their partnership through coordination, collaboration, and integration. What follows are courses of action which build additional capacity and leverage the aforementioned challenges and opportunities affecting the DoD-VA health care partnership.

Recommendations for Building Capacity

In addition to the provisions of the Wounded Warrior Act, the DoD-VA Joint Executive Council should implement the following recommendations:

(1) Place greater emphasis on health promotion and preventive measures to improve patient quality of life and promote cost savings.[68] Given the recent interest in universal access to limited health care resources, the nation's leaders will look to the DoD and VA health care systems- as the closest examples of U.S. based universal health care systems- to identify ways to provide affordable and accessible health care. Emphasizing illness prevention ahead of disease management and treatment will help shape which direction the nation ultimately takes in pursuit of universal access to care for all Americans.

(2) Combine DoD and VA health care professionals into one work force. Advantages of unifying the work force include: eliminating interagency competition for the same pool of professionals; mitigating the nursing shortage by drawing on a larger pool of nurses to better manage nursing requirements; creating a pool of civilian professionals who can deploy to “fixed” hospitals in mature Theaters of Operation; improving opportunities to maintain medical and surgical expertise by placing physicians at the best DoD or VA institution to support professional MOC requirements. A good starting point for this recommendation is the creation of a single system to credential and certify all DoD and VA physicians and nurses.

(3) Merge DoD and VA GME into a single consortium. The VA has a significant track record of training the nation’s health care professionals. Currently, over half of U.S. practicing physicians received some of their training in a VAMC.[69] Given the long duration necessary to wage a successful counterinsurgency, DoD GME and physician recruiting will remain under duress for the foreseeable future. Partnering with the VA allows the DoD an opportunity to still participate in GME while enabling more “teaching” physicians to deploy in support of expeditionary and contingency operations. Perhaps now is a good time to revisit the issue of GME as a core DoD competency.[70]

(4) Keep senior DoD and VA health care leaders in place until new Presidential administrations are fully operational. Arguably this is already happening at the Deputy DoD and VA level. However, the advantage of keeping the Secretary of the VA for at least a year after a new administration comes to power would signal the desire to keep Veterans’ health care above the political fray. A similar argument could be made once the Unified Medical Command is established and a Commander is identified.

(5) Build Federal Health Care Centers in lieu of separate VAMCs and MTFs. The JEC Strategic Performance Measure 5.4 (e) for FY 2008-2010 calls for the identification of health care markets that serve large DoD and VA populations.[71] If a site visit validates significant sharing opportunities, FHCCs should be built at these locations.

(6) Support the JEC Transition Working Group in developing additional LOO to support a seamless transition for all Veterans. In particular, a greater emphasis should be placed on identifying Soldiers at risk for veteran homelessness and chronic PTSD. The risk factors for these conditions- traditionally areas of concern only to the VA- are already known.[72] What is needed is an integrated approach to prospectively identify, counsel, and if necessary treat at-risk active-duty Soldiers.

(7) Develop a seamless and "bi-directional" system to allow interested retired Veterans who have successfully undergone long-term rehabilitation in the VA to return to active-duty. These Veterans are loyal to the military, and if given the opportunity, would make significant contributions to the DoD.

Embracing these recommendations will build capacity in the DoD-VA health care partnership ahead of the impending health care crisis. As most of these recommendations can be implemented without the need for additional legislation, the question which remains is whether the DoD-VA JEC will implement the recommended changes without Congressional prodding and before catastrophe strikes. The research indicates that the JEC is more willing than ever before to accept far-reaching recommendations- especially if these recommendations demonstrate DoD-VA resolve and commitment to accelerate the pace of collaboration. Given the hypothetical nature

of this discussion, what options exist if the DoD-VA JEC somehow becomes impotent or fails to see value in these recommendations?

Options for Further Interagency Reform Legislation

IAR experts are certain to cite the absence of unity of command as a flaw in the current DoD-VA JEC construct.[73] The Senior Oversight Committee is an attempt to provide additional accountability but the SOC does not have final arbitration authority when there is major disagreement between the DoD and VA. How then can Congress strengthen DoD-VA collaboration to ensure resiliency ahead of the coming health care crisis? More specifically, which level or proportion of IAR legislation is necessary and appropriate to help the JEC avert a federal health care system disaster? Potential options include: incremental IAR legislation to "tweak" the current partnership; moderate IAR legislation revising SOC membership to include Executive Branch leaders- senior to DoD-VA JEC executives- with arbitration authority; and major IAR legislation merging the DoD and VA to obviate the need to improve interagency coordination as these two health care systems would become one. Examination of each option using the FAS test follows.

There are distinct advantages to merging the DoD and VA health care systems. Holistically, a merger provides a greater sense of direction- a better long-term vision- than just "improving collaboration." The inherent unity of command from such a merger would certainly accelerate the decision making process. Successful execution of LOO would be easier in theory as coordination would be intra-agency instead of interagency. Thus, a merger would potentially benefit both patients and health care professionals. Obviously, issues over governance, money, personnel, and facilities would have to be

resolved before the merger could proceed. Further, review of the BG-N Phase II Report suggests that major IAR will not be possible without the generation of a requisite amount of critical mass.[74] Unfortunately, in this situation, the necessary quantity critical mass remains unknown. The imminent national health care crisis may not be enough to force massive legislative changes to the current partnership. For the time being, this option is suitable and acceptable but not feasible.

Moderate reform through legislation strengthening the SOC would require that the membership of this organization change significantly. Much like a Corporate Board of Directors, the organization would include members outside of the DoD and VA health care system. This new SOC would essentially have unity of command with final decision making authority. History however is replete with examples of governing bodies that made inappropriate decisions for subordinate organizations that they knew little about. Even if SOC members were found from within the remaining government health care organization- the Department of Health and Human Services, concerns over the appropriateness of DoD and VA specific expertise, apportionment of time to adequately oversee the nation's two largest health care organizations, and inability to realistically run three cabinet level Departments simultaneously would certainly arise. Thus, although strengthening the Senior Oversight Committee has distinct advantages- namely unity of command, determining the optimal composition of the SOC remains problematic. As the SOC is currently composed of senior DoD and VA leaders, this Committee is essentially a larger JEC. As already noted, there is minimal value in keeping the SOC. This option is neither acceptable nor suitable. What remains then is the last, simplest, and arguable the best course of action for minimizing the impact of

the impending health care crisis: incremental IAR legislation to build capacity between the DoD and VA.

Absent self-reform, incremental IAR legislation is the most painless and proven way to develop DoD-VA interagency resiliency ahead of the coming health care crisis.[75] The recent of addition of performance measures in the JEC strategic plan provides a mechanism to quickly synchronize DoD-VA collaborative efforts to effectively deal with new and complex challenges. Senior DoD and VA executives understand the importance of making significant and steady progress toward enhancing DoD-VA collaboration. Failure to embrace incremental but necessary IAR would open the proverbial door for another WR-like catastrophe, further scrutiny, and eventual major IAR legislation. This scenario is an unacceptable course of action but remains a possibility in this highly critical post-WR environment. In essence then, incremental IAR legislation meets all the requirements of the FAS test. Short of self-reform, this option is the best way to help the DoD-VA JEC mitigate the effects of the impending health care crisis.

Conclusion

Examination of the DoD-VA health care partnership in the aftermath of Walter Reed is an excellent opportunity to study the timing, proportion, and necessity of interagency reform legislation in improving interagency collaboration. This case study demonstrates that the DoD-VA health care partnership has improved dramatically over time and its Joint Executive Council is now well suited to implement the provisions of the Wounded Warrior Act. The legacy of this partnership will ultimately depend on its ability to successfully transform ahead of the impending U.S. health care catastrophe.

This catastrophe is a result of multiple different but related factors present or foreseeable. Implementing the seven recommendations identified will strengthen DoD-VA coordination and build further capacity. Incremental IAR legislation is currently the only feasible, acceptable, and suitable option in the event that the DoD-VA health care partnership cannot or will not implement these recommendations. The Joint Executive Council, however, is more willing than ever to accept far-reaching recommendations to further demonstrate its commitment to the DoD-VA health care partnership. Success of this partnership will arguably provide the first template for major interagency "transformation before catastrophe." More importantly, embracing these recommendations will secure the DoD-VA partnership's position as a model for universal access to health care for all Americans.

Endnotes

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[23] Ibid.

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[38] U.S. Congress, Senate, Committee on Veterans Affairs, *DoD-VA Cooperation and Collaboration to Meet the Needs of Returning Servicemembers: S.C. Chu Prepared Statement before the U.S. Senate Committee on Veterans Affairs*, 109th Cong., 1st sess., 23 January 2007, available from http://www.senate.gov/~svac/public/index.cfm?pageid=16&release_id=10762&sub_release_id=11040&view=all; Internet; accessed 2 January 2008 and U.S. Department of Veterans Affairs and Department of Defense, *VA/DoD Joint Executive Council Fiscal Year 2006 Annual Report* (Washington D.C.: U.S. Department of Veterans Affairs and Department of Defense, February 2007),1-34, available from http://www.tricare.mil/DVPCO/downloads/VADoD2006.pdf; Internet; accessed 2 December 2007. Dr. Chu identified: DoD sharing agreements with 157 VA Medical centers; 47 JIF Projects accounting for $88.8 million of $90 million in the fund; seven health care coordination projects (only 3 were mandated by the FY 2003 NDAA; 159 collaborative agreements involving education, and training; seamless transition initiatives- 103 memorandums of understanding between the DoD and VA for a cooperative physical exam process; a Army Liaison/VA Polytrauma Rehabilitation Center program; Joint Seamless Transition Program for severely injured Service members; expanded collaborative programs in

deployment health, evidence based clinical practice guidelines, and patient safety; enhanced efficiency of operations through 46 shared contracts for medical and surgical equipment- $201.5 million in purchased from $170 million in FY 2006; 77 joint National Pharmacy Working Group Contracts with a combined cost avoidance of $423 million; information sharing: Federal Health Information Exchange data transfer for 3.6 million patients; and improved information sharing with 580,000 letter send out from the VA to Soldiers in Combat Theatres.

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